

## HEALTH HISTORY QUESTIONNAIRE

Date: \_\_\_\_\_

<b>Name:</b>						
Street Address:						
City:		State:		Zip:		
Home Phone:			Daytime Phone:			
Email Address:						
Age:	Date of Birth:		Employer:			
Insurance company:			Insurance ID#:			
Name of Insured & DOB (if different):				Insurance Group#:		
Where did you spend most of your childhood?				Place of Birth:		
When did you move to the Eugene area?						
<b>Relationships:</b>	Single <input type="checkbox"/>	Married <input type="checkbox"/>	Partnered <input type="checkbox"/>	Separated <input type="checkbox"/>	Divorced <input type="checkbox"/>	Widowed <input type="checkbox"/>
In emergency, please notify:			Relationship:		Phone:	
Name of the person who referred you to this office:						

<b>Main health issue(s)</b> you would like me to help you with:				
How long ago did this become an issue?				
To what extent does this issue interfere with your daily activities (work, sleep, sex, etc...)?				
Have you been given a diagnosis for this issue? If so, what?				
Check the following therapies ever used in past:		Acupuncture <input type="checkbox"/>	Massage <input type="checkbox"/>	Herbs <input type="checkbox"/>
List any therapies you are employing for the current condition:				
When were you last seen by a medical doctor (date or approximate year):				
Name of physician:		Reason for visit:		

<b>Past Medical History</b> (include date):		Cancer:	Diabetes:	Hepatitis:
High Blood Pressure:	Heart Disease:	Rheumatic Fever:	Thyroid Disease:	
Seizures:	Venereal Disease:	Other:		
<b>Surgeries</b> (type of and date):				
<b>Significant Trauma</b> (auto accidents, falls, etc.):				

<b>Significant Dental Work</b> (type of and date):					
<b>Your birth history</b> (prolonged labor, forceps delivery, etc.):					
<b>Allergies</b> (drugs, chemicals, foods/result of exposure):					
<b>Medicines</b> taken within the last two months (vitamins, drugs, herbs, etc.):					
<b>Family Medical History</b> (check):		Diabetes <input type="checkbox"/>	Cancer <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>	Heart Disease <input type="checkbox"/>
Stroke <input type="checkbox"/>	Seizures <input type="checkbox"/>	Asthma <input type="checkbox"/>	Allergies <input type="checkbox"/>	Other (specify) <input type="checkbox"/>	

<b>Occupational Stress</b> (chemical, physical, psychological, etc.):			
Do you have a <b>regular exercise program</b> ? Yes <input type="checkbox"/> No <input type="checkbox"/> Please describe:			
Have you ever been on a <b>restricted diet</b> ? Yes <input type="checkbox"/> No <input type="checkbox"/> Please describe:			
What did you have for your most recent:			
<b>Breakfast:</b>			
<b>Lunch:</b>			
<b>Dinner:</b>			
<b>Snack:</b>			
How many <b>packs of cigarettes</b> do you smoke <b>per day</b> ?			
How much <b>alcohol</b> do you drink <b>per week</b> ?			
How much <b>coffee, tea, or cola</b> do you drink per day?			
Please describe any use of <b>other drugs</b> for <b>non-medical purposes</b> :			

What is your work and do you enjoy it?	
If not working, what are your main activities?	
Who do you live with?	
Does that relationship have any significant problems currently?	
What do you consider your current stress level to be (low to high, etc.)?	
What is your greatest source of joy/satisfaction?	
What is your greatest source of sadness/frustration?	
Do you attend a church, synagogue, temple, or other religious institution?	
Do you consider yourself a spiritual person?	Do you practice meditation or contemplative prayer?

**For women only:** (Please check all that are or have been applicable to you – if past, indicate age or date.)

- |   |   |
|---|---|
| <input type="checkbox"/> Irregular period             | <input type="checkbox"/> Took birth control pills |
| <input type="checkbox"/> Scanty period                | <input type="checkbox"/> Nervousness              |
| <input type="checkbox"/> No period                    | <input type="checkbox"/> Fluid retention          |
| <input type="checkbox"/> Heavy period                 | <input type="checkbox"/> PMS                      |
| <input type="checkbox"/> Tender breasts before period | <input type="checkbox"/> Mood swings              |
| <input type="checkbox"/> Decreased sex drive          | <input type="checkbox"/> Habitual miscarriage     |
| <input type="checkbox"/> Infertility                  | <input type="checkbox"/> Vaginal discharge        |
| <input type="checkbox"/> Sweet cravings               | <input type="checkbox"/> Difficulty breastfeeding |
| <input type="checkbox"/> Breast pain                  | <input type="checkbox"/> Uterine fibroids         |
| <input type="checkbox"/> Breast lumps                 | <input type="checkbox"/> Uterine hemorrhage       |

Age when started menses: \_\_\_\_\_ Age when started menopause: \_\_\_\_\_

Pregnancies: \_\_\_\_\_ Age: \_\_\_\_\_

Miscarriages: \_\_\_\_\_ Age: \_\_\_\_\_

Abortions: \_\_\_\_\_ Age: \_\_\_\_\_

**For men only:** (Please check all that are or have been applicable to you – if past, indicate age or date.)

- |   |  |
|---|--|
| <input type="checkbox"/> Decreased sex drive          | <input type="checkbox"/> Impotency                 |
| <input type="checkbox"/> Low sperm count              | <input type="checkbox"/> Exhaustion after sex      |
| <input type="checkbox"/> Difficult urination          | <input type="checkbox"/> Nighttime urination       |
| <input type="checkbox"/> Scanty ejaculation           | <input type="checkbox"/> Premature ejaculation     |
| <input type="checkbox"/> Loss of force when urinating | <input type="checkbox"/> Dribbling after urination |

**For All:** (Please check all that are or have been applicable to you – if past, indicate age or date.)

**General:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Poor appetite                   | <input type="checkbox"/> Fevers                         | <input type="checkbox"/> Sweat easily              |
| <input type="checkbox"/> Localized weakness              | <input type="checkbox"/> Bleed or bruise easily         | <input type="checkbox"/> Peculiar tastes or smells |
| <input type="checkbox"/> Strong thirst (for hot or cold) | <input type="checkbox"/> Thirst, but no desire to drink | <input type="checkbox"/> Sudden energy drop        |
| <input type="checkbox"/> Poor sleeping                   | <input type="checkbox"/> Chills                         | <input type="checkbox"/> Tremors                   |
| <input type="checkbox"/> Poor balance                    | <input type="checkbox"/> Fatigue                        | <input type="checkbox"/> Night sweats              |
| <input type="checkbox"/> Cravings, for what: _____       | <input type="checkbox"/> Change in appetite             | <input type="checkbox"/> Weight gain               |
| <input type="checkbox"/> Weight loss                     |   |  |

**Skin and Hair:**

- |   |   |                                   |
|---|---|-----------------------------------|
| <input type="checkbox"/> Rashes                 | <input type="checkbox"/> Itching                      | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Change in hair or skin | <input type="checkbox"/> Ulcerations                  | <input type="checkbox"/> Eczema   |
| <input type="checkbox"/> Loss of hair           | <input type="checkbox"/> Hives                        | <input type="checkbox"/> Pimples  |
| <input type="checkbox"/> Recent moles           | <input type="checkbox"/> Other, please specify: _____ |                                   |

**Head, eyes, ears, nose and throat:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Dizziness                     | <input type="checkbox"/> Glasses                         | <input type="checkbox"/> Poor vision            |
| <input type="checkbox"/> Cataracts                     | <input type="checkbox"/> Ringing in the ears             | <input type="checkbox"/> Sinus problems         |
| <input type="checkbox"/> Teeth grinding                | <input type="checkbox"/> Teeth problems                  | <input type="checkbox"/> Eyes strain            |
| <input type="checkbox"/> Night blindness               | <input type="checkbox"/> Blurry vision                   | <input type="checkbox"/> Poor hearing           |
| <input type="checkbox"/> Nose bleeds                   | <input type="checkbox"/> Facial pain                     | <input type="checkbox"/> Jaw clicks, aches      |
| <input type="checkbox"/> Migraine                      | <input type="checkbox"/> Eye pain                        | <input type="checkbox"/> Color blindness        |
| <input type="checkbox"/> Earaches                      | <input type="checkbox"/> Spots in front of the eyes      | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Sores on lips or inside mouth | <input type="checkbox"/> Headaches, where on head: _____ |   |
| <input type="checkbox"/> Other, please specify: _____  |  |   |

**Cardiovascular:**

- High blood pressure
- Blood clots
- Swelling of hands
- Fainting
- Other heart or blood vessel problems: \_\_\_\_\_
- Irregular heartbeat
- Low blood pressure
- Phlebitis
- Swelling of feet
- Cold hands and feet
- Dizziness
- Chest pain
- Difficulty breathing

**Respiratory:**

- Cough
- Coughing or blowing nose w/ phlegm: what color? \_\_\_\_\_
- Pneumonia
- Other lung or breathing problems: \_\_\_\_\_
- Bronchitis
- Asthma
- Difficulty breathing lying down
- Coughing blood
- Pain on breathing

**Gastrointestinal:**

- Nausea
- Black stools
- Chronic laxative use
- Blood in stools
- Indigestion
- Other stomach or intestinal problems: \_\_\_\_\_
- Constipation
- Bad breath
- Vomiting
- Rectal pain
- Hemorrhoids
- Diarrhea
- Abdominal pain or cramps
- Gas
- Belching

**Genito-Urinary:**

- Pain on urination
- Unable to hold urine
- Sores on genitals
- Urgency to urinate
- Blood in urine
- Other kidney or urogenital problems: \_\_\_\_\_
- Decrease in flow
- Kidney stones

**Musculoskeletal:**

- Neck pain
- Muscle pain
- Knee pain
- Other: \_\_\_\_\_
- Back pain
- Muscle weakness
- Foot/ankle pain
- Hand/wrist pain
- Shoulder pain
- Hip pain

**Neuropsychological:**

- Seizures
- Bad temper
- Depression
- Poor memory
- Areas of numbness
- Dizziness
- Easily susceptible to stress
- Anxiety
- Concussion
- Lack of concentration
- Loss of balance
- Other: \_\_\_\_\_

**Please rate the degree of severity of your problem right now (mark an X):**

0 \_\_\_\_\_ 10  
None Worst Imaginable

<b>Comments:</b> (please tell me about any other issue(s) you would like to discuss):